STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	002578	A. BUILDING: _____ B. WING _____	10/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY SURGERY CENTER HAMILTON	9700 E 146TH ST NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS Surveyor 333212 Facility #: 002578 Type of Survey: State Licensure Off site AAAHC Accreditation Survey Date of AAAHC on site survey:10/2-3/2012 Date of off-site ISDH review 09/03/2013 Based on review of the 10/3/2012 AAAHC Accreditation Survey Report, Hamilton Surgery Center meets the requirements for State Licensure for 2012, in Indiana.	S 000		